

## RETURNED WARRANT INQUIRY

TO: DEPT OF HEALTH CARE SERVICES

DATE PROCESSED: 01/16/2008

FROM: DISBURSEMENTS BUREAU, POST ISSUANCE UNIT  
P.O. BOX 942850, SACRAMENTO, CA 94250  
(916) 323-5162, ATSS: 473-5162-----  
WARRANT NUMBER: [REDACTED] ISSUE DATE: 01/10/2008  
WARRANT AMOUNT: \$ 90.05 CLAIM SCHEDULE: 17056  
FUND: 0912 HEALTH CARE DEPOSIT FUND

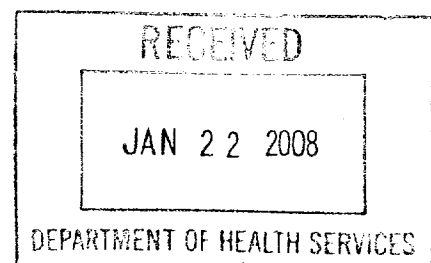
PAYEE NAME: [REDACTED]

ID: [REDACTED]

ADDRESS: [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]-----  
THE ABOVE WARRANT WAS RETURNED TO THIS OFFICE. IF THE RETURNED ENVELOPE  
CONTAINED PERTINENT INFORMATION, IT IS ATTACHED. ANY CORRESPONDENCE FROM  
THE PAYEE IS ALSO ATTACHED. IF THE WARRANT WAS RETURNED BY THE POST OFFICE  
AND THE ENVELOPE DID NOT CONTAIN IMPORTANT INFORMATION, IT IS NOT ATTACHED.COMPLETE THE LOWER PORTION AND RETURN THE ENTIRE FORM PROMPTLY. IF NO REPLY  
IS RECEIVED WITHIN 30 CALENDAR DAYS, THE WARRANT WILL BE DEPOSITED INTO YOUR  
ESCHEAT REVENUE ACCOUNT IN THE FUND FROM WHICH IT WAS DRAWN.-----  
TO: CONTROLLER'S OFFICE  
DISBURSEMENTS BUREAU, POST ISSUANCE UNIT-----  
REMAIL. ATTACH NEW OR CORRECTED REMITTANCE ADVICE TO THE UPPER BACK  
OF THIS FORM.  
DEPOSIT INTO ESCHAT REVENUE ACCOUNT IN FUND FROM WHICH IT WAS DRAWN.  
DEPOSIT INTO THE FUND FROM WHICH IT WAS DRAWN.  
-----WARRANT WILL NOT BE PROCESSED WITHOUT AUTHORIZING SIGNATURE AND DATE.  
"BY MY SIGNATURE BELOW, I CERTIFY THE ABOVE INFORMATION IS COMPLETE AND  
ACCURATE."-----  
(AGENCY REPRESENTATIVE NAME AND TITLE)-----  
(DATE)X 927 NDE 1 1071 02 01/14/08  
FORWARD TIME EXP RTN TO SEND  
[REDACTED]  
[REDACTED]

RETURN TO SENDER

[REDACTED]



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